MIDWEST OPERATING ENGINEERS WELFARE FUND

6150 Joliet Road
Countryside, Illinois 60525
(708) 482-7300

Name of Member _____ Date of Birth _____

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ____

Medical ID # _____ Telephone No. (____) _____

Home Address _____

Spouse's Name _____ Date of Birth _____

Spouse's Employer Name _____

Address _____ Phone (____) _____

IF THIS CLAIM IS FOR YOUR DEPENDENT

Name of Dependent (First) _____ Last _____ Date of Birth _____

Relationship to Member Spouse ____ Son ____ Daughter ____ Other ____

Is Dependent Employed? Yes ____ No ____

If Yes, Provide Employer Name _____

Address _____

City, State, Zip _____

IF YOU OR YOUR DEPENDENT HAVE ANY OTHER GROUP INSURANCE

Insured's Name _____

Type: Insurance _____ Medicare _____ Health Maintenance (HMO) _____

Insurance Company Name _____

ABOUT THIS CLAIM

* Describe sickness or injury _____

* Was the condition the result of an accident or injury? Yes ____ No ____

* If yes, tell us how and where (address) it happened _____

_____

_____

* Date accident occurred or sickness began _____ Date first treated _____

* Did condition occur in the course of employment? Yes ____ No ____

MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release when requested by the Health and Welfare Fund, of any facts concerning the injury, illness, or treatment of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

X Member's Signature _____ Dated _____

I AUTHORIZE PAYMENT OF BENEFITS TO THE PROVIDER(S)

X Member's Signature _____
(Spouse cannot sign)